Indiana Department of Insurance
Filing Company Checklist
GROUP MEDICARE SUPPLEMENT Review Standards

(Checklist must be submitted with filing.)

Company Name_____ NAIC # _____

Form number(s)_____ Filing date_____

Statute/Regulation	*Requirement*	*N/A*	*Location in submitted documents*	*For IDOI USE ONLY Yes/No/Comments*
General Filing Requirements				
IC 27-1-3-15	***Filing Fee***—We will bill you quarterly for **each** form contained in the filing and for **each** company the form is filed for. The per form fee is $35 or the retaliatory fee based on your state of domicile. **PLEASE DO NOT** submit any filing fees with your filing.			
Bulletin 125	NAIC Standard A&H Transmittal Sheet— Use coding from NAIC Uniform Product Coding Matrix— Links to these items on the IDOI website or www.naic.org			
IC 27-1-26	Flesch readability certification			
Bulletin 125	A cover letter (ONLY if all the following information is not included on the NAIC Standard A&H Transmittal Sheet):			
	a) A reference "Re:" line with the insurance company's name and NAIC number, and the form number of **each** form to be filed.			
	b) If there are numerous forms in one filing, please list them on a separate sheet of paper and indicate in the reference line "see attached list." Please list the most important form first and keep the same order in related correspondence			
	c) The name of a contact person, w/ e-mail address, telephone and fax numbers. **All correspondence will be done via e-mail when possible.** On all e-mails and other correspondence, please include NAIC number, Company Name and lead form number. Any submission of additional forms or materials should include a separate response letter, for each filing being addressed.			
Bulletin 125	A postage-paid, self-addressed envelope of adequate size to hold the "approved" or "filed" stamped duplicate correspondence and any extra copies of forms that you wish to have returned. (There is no need to send more than one copy of the forms.)			
Bulletin 125	If the filing is submitted by an outside consulting firm, a letter giving authorization to file on behalf of the company. If you are filing for multiple companies, you must submit an authorization from each company, list each company separately on the cover letter by NAIC #, Company Name and form #.			

Required Provisions for Med Supp Policies	The following rights of insurers and insureds must be disclosed in policies issued in Indiana. Exact wording is not required, as long as the substance matches the statutory language, or is more favorable to the insured or policyholder.			
IC 27-8-5-19(c)(1)	**GRACE PERIOD**: The policyholder has a grace period of 31 days for payment of premium due, except the first premium. Policy remains in force during the grace period, but insurer may hold claims incurred during grace period until premium is received.			
IC 27-8-5-19(c)(2)	**INCONTESTABILITY**: Validity of policy may not be contested after 2 years except for a) nonpayment of premiums, or if b) the disputed statement is in a written instrument signed by insured. Ineligibility of insured or enrollee under the policy may be disputed any time.			
IC 27-8-5-19(c)(3)	**COPY OF APPLICATION**: If there is an application, a copy must be attached to the policy at issue. Statements made by persons insured are representations, not warranties, and must be provided to insured persons in case of a dispute.			
IC 27-8-5-19(c)(4)	**EVIDENCE OF INSURABILITY**: Insurers may reserve the right to require individual evidence of insurability as a condition of coverage.			
IC 27-8-5-19(c)(7)	**MISSTATEMENT OF AGE**: Clear statement of how premiums, benefits or both will be fairly adjusted if covered person's age is misstated and if premiums and benefits vary by age.			
IC 27-8-5-19(c)(8)	**CERTIFICATE**: Insurer must issue to policyholder, for delivery to each insured person, a certificate of coverage explaining the protection, to whom the benefits are payable, and each family member and dependent's coverage. (See below for debtor's certificate.)			
IC 27-8-5-19(c)(9)	**TIMELY NOTICE OF CLAIM**: Insured must provide written notice of claim within 20 days after occurrence or commencement of loss, or as soon as reasonably possible.			
IC 27-8-5-19(c)(10)	**CLAIM FORMS**: Insurer must provide forms for filing proof of loss within 15 days of notice of claim, or claimants can submit their own.			
IC 27-8-5-19(c)(11)	**PROOF OF LOSS**: Written proof must be furnished within 90 days after the date of loss. Failure to furnish proof within 90 days does not invalidate or reduce any claim if it was furnished as soon as reasonably possible but no later than one year from time proof is otherwise required.			
IC 27-8-5-19(c)(12)	**TIMELY PAYMENT OF CLAIMS**: All benefits payable under the policy (other than benefits for loss of time) will be paid within 30 days if filed electronically or within 45 days if filed on paper.			
IC 27-8-5-19(c)(13)	**BENEFICIARIES**: Loss of life benefits are paid to the beneficiary designated by the insured. If the policy contains conditions pertaining to family status the policy terms apply. All other benefits payable to the person insured. Insurer may also choose to pay up to $5000 to a relative by blood or marriage if beneficiary is an estate or a minor. (Does not apply to policies insuring lives of debtors.)			
IC 27-8-5-19(c)(14)	**PHYSICAL EXAMINATION AND AUTOPSY**: Insurer has the right to examine the person during the pending of a claim or to conduct an autopsy in case of death, unless prohibited by law.			
IC 27-8-5-19(c)(15)	**LEGAL ACTIONS**: No lawsuit may be filed to recover under the policy before 60 days after proof of loss is filed, and not later than 3 years after proof of loss is required to be filed.			
IC 27-8-13-9	**DUPLICATE BENEFITS**: A Med Supp policy, contract, or certificate may not contain benefits that duplicate benefits provided by Medicare. A *change* in coverage that becomes effective after a Med Supp policy, contract, or certificate and that causes a duplication of benefits does not void the policy, contract, or certificate.			

IC 27-8-13-17	**RETURN PRIVILEGE**: Med Supp policies and certificates must have a notice prominently printed on the first page (or attached to the first page) stating the applicant has the right to return the policy or certificate within 30 days of delivery and to have premium refunded if applicant is not satisfied.			
760 IAC 3-2-6 760 iAC 3-3-1	**DEFINITIONS**: No policy or certificate may be advertised, solicited, or issued for delivery as a Medicare Supplement policy or certificate unless the definition of Medicare is included in the policy or certificate. Medicare defined is the "Health Insurance for the Aged Act." Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended."			
760 IAC 3-5-1(b)(1) 760 IAC 3-6-1(b)	**PRE-EXISTING CONDITION**: A Medicare Supplement policy or certificate shall not a) exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a pre-existing condition or b) define a pre-existing condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.			
760 IAC 3-9-1	**OPEN ENROLLMENT:** Issuer shall not deny or condition the issuance or effectiveness of any Medicare Supplement policy or certificate or discriminate the pricing of the policy or certificate because of health status, claims experience, receipt of health care, or medical condition of applicant submitting before or during the six (6) month period when individual is both 65 or older and enrolled under Medicare Part B. All plans currently available will be made available to those who qualify regardless of age.			
760 IAC 3-11-1	**LOSS RATIO STANDARDS & REFUND OF PREMIUM:** a) Policy form or certificate form is expected to return at least 75% of the aggregate amount of premiums earned. b) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level.			
760 IAC 3-13-1	**COMMISSION**: a) May be provided to an agent or other representative only if the first year commission is no more than 200% of the commission paid for selling or servicing the policy or certificate in the second year. b) Commission paid in renewal years must be the same as commission in the 2nd year and must be paid for no fewer than 5 renewal years.			
760 IAC 3-14-1	**REQUIRED DISCLOSURES**: Language or specifications shall be consistent with the type of contract issued. The provision shall a) be appropriately captioned b) appear on the first page of the policy and c) include any reservation by the issuer of the right to change premiums and include automatic renewal premium increases based on the policyholder's age.			
760 IAC 3-15-1	**APPLICATION FORMS / REPLACEMENT COVERAGE**: a) Shall include statements and questions designed to elicit information as to whether the applicant has another Medicare supplement, Medicare Advantage, or Medicaid coverage or another health insurance policy or certificate in force or whether a Med Supp policy or certificate is intended to replace any other accident and sickness policy or certificate currently in force. b) Replacement of Med Supp coverage requires a notice be provided in similar form to "NOTICE OF APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE. SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE."			
760 IAC 3-17-1	**MARKETING**: Shall display prominently by type, stamp, or other appropriate means, on the first page of the policy, "Notice to buyer: This policy may not cover all of your medical expenses."			
Bulletin 128	**FILING COMPLAINTS**: Notice to policyholders regarding filing complaints with the Department of Insurance			
See citations above	All coverage marked with a single asterisk must be offered to non-employer-based groups			

MED SUPP Plans				
Plan A 760 IAC 3-6-1	-Core benefits included in all plans and pays 1) Part A Hospital co-payment for 61-90 days and another co-payment for 91-150 days 2) Additional 365 days of hospitalization after Medicare benefits end 3) Part B co-payment, usually 20% of Medicare approved amount 4) First three pints of blood per year			
Plan B 760 IAC 3-6-1	-Core benefits -Part A Deductible (inpatient hospital deductible)			
Plan C 760 IAC 3-6-1	-Core benefits -Skilled Nursing Co-payment : for days 21-100 in SNF -Part A Deductible -Part B Deductible (for physical or other OP services) -Foreign Travel Emergency (Medicare does not pay for care received in a foreign country.) MS covers, after a $250 deductible, 80% of health expenses for emergency care received n the first 60 days to a lifetime max of 50k			
Plan D 760 IAC 3-6-1	-Core benefits -Skilled Nursing Co-payment -Part A Deductible -Foreign Travel Emergency -At-home Recovery (Medicare only pays for skilled nursing home health care.) MS covers home health visits for help with daily living when Medicare is received or within 8 weeks from the last Medicare visit			
Plan E 760 IAC 3-6-1	-Core benefits -Skilled Nursing Co-payment -Part A Deductible -Foreign Travel Emergency -Preventive Care not covered by Medicare: covers annual preventive exam and services to an annual max			
Plan F 760 IAC 3-6-1	-Core benefits -Skilled Nursing Co-payment -Part A Deductible -Part B Deductible -Part B excess (80%):Medicare does not pay excess charges above its approved amount.. Part B Excess covers the difference between the Medicare approved amount and the limiting charge (no more than 15% above Medicare approved amount). Pays either 80% or 100% of Part B excess charges -Foreign Travel Emergency			
Plan G 760 IAC 3-6-1	-Core benefits -Skilled Nursing Co-insurance -Part A Deductible -Part B excess (100%) -Foreign Travel Emergency -At-home Recovery			
Plan H 760 IAC 3-6-1	-Core benefit -Skilled Nursing Co-insurance -Part A Deductible -Foreign Travel Emergency			
Plan I 760 IAC 3-6-1	-Core Benefit -Skilled Nursing Co-insurance -Part A Deductible -Part B excess (100%) -Foreign Travel Emergency -At-home Recovery			
Plan J 760 IAC 3-6-1	-Core benefits -Skilled Nursing Co-insurance -Part A Deductible -Part B Deductible -Part B excess (100%) -Foreign Travel Emergency -At-home Recovery -Preventive care not covered by Medicare			

Plan K 760 IAC 3-6-1	-Core benefits: 1)100% of Part A co-insurance plus 365 days after Medicare benefits end 2) 50% hospice cost-sharing 3)50% of Medicare-eligible expenses for 1st 3 pints of blood 4)50% Part B co-insurance except 100% for Part B preventive services -50% Skilled Nursing Co-insurance -50% Part A Deductible -Out-of-Pocket annual limit :increases each year w/inflation			
Plan L 760 IAC 3-6-1	-Core benefits: 1)100%of Part A co-insurance plus 365 days after Medicare benefits end 2)75% hospice cost-sharing 3)75% of Medicare-eligible expenses for 1st 3 pints of blood 4)75% Part B co-insurance except 100% for Part B preventive services -75% Skilled Nursing Co-insurance -75% Part A Deductible -Out-of-Pocket annual limit :increases each year w/inflation			
760 IAC 3-8-1	**MEDICARE SELECT**: 1) A Medicare Select issuer shall not issue a policy or certificate until its plan of operation has been approved by the commissioner; 2) Disclosure provisions; 3) Written grievance procedures for hearing complaints and resolving written grievances shall be used.			
General Regulatory Issues	Under the authority provided by IC 27-1-4 the Department monitors various issues that have been determined to be unfair, misleading or potentially constitute unfair trade practices. The following issues will also be reviewed.			
Application questions 27-8-5-1(d)(2) 27-8-5-1.5(l)	1. Questions regarding an applicant's health cannot inquire about non-specific conditions prior to the most recent five years. 2. Questions inquiring if an applicant has had signs or symptoms of a condition are not permitted. 3. Small employer applications may not require applicants declining coverage to complete health questions.			
Arbitration 27-8-5-1(d)(2)	Mandatory and/or binding arbitration provisions are prohibited.			
First manifest language 27-8-5-19(c)(6) 27-8-5-2.5 27-8-15-27	Typically first manifest type language creates a permanent exclusion of coverage related to a condition present any time prior to the effective date of coverage contrary to any pre-existing condition provisions included in the form. Such inconsistencies are not permitted.			
Foreign language forms Bulletin 106	Foreign language forms must comply with Bulletin 106.			
Large endorsements 27-8-5-1(d)(2) 27-8-5-1.5(l)	The Department does not allow use of large or confusing endorsements to bring contracts into compliance. In such cases the entire contract should be refiled to incorporate the multiple changes. On a similar note, Indiana specific certificates should be filed rather than file an endorsement to revise another state's certificate.			
Open endorsements 27-8-5-1(d)(2) 27-8-5-1.5(l)	Highly flexible or "blank check" type endorsement forms that provide unlimited ability to revise forms without regulatory review are not allowed.			
Privacy of health information 27-8-5-1(d)(2) 27-8-5-1.5(l)	Employers cannot be asked to reveal or certify the accuracy of any knowledge they may have regarding an individual's health condition.			
Various fees 27-8-5-1(d)(2) 27-8-5-1.5(l)	Fees charged to accept or process an application are not allowed. One-time fees such as may be charged to issue a policy are acceptable providing they are clearly labeled and accompanied by a disclosure that the fee is fully refundable if the policy is not issued, not taken or returned during the "free look" period.			
Bulletin 103	No full and final discretion clauses except where policy is governed by ERISA			
760 IAC 1-8	Use of terms "Noncancellable" and "Guaranteed Renewable" must not be misleading			
27-8-5-1(d)(2) 27-8-5-1.5(l)	The policy form cannot contain provisions that are unjust, unfair, inequitable, misleading, or deceptive, or that encourage misrepresentation of the policy.			

I hereby certify, pursuant to IC 27-8-5-1.5(i)(1)(C), that the policy form submitted with this checklist meets all requirements of Indiana law.

Filer: _____

Printed: _____

Company: _____

Title: _____

Date: _____